Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLEN S KENT MD PA
800 12th AVENUE SUITE 200
FORT WORTH TEXAS 76104

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN CASUALTY CO OF READING

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-07-3983-01

MFDR Date Received
March 2, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the table of disputed services: "This service has no MAR and a voluntary pre-authorization was obtained which listed the total amount the insurance carrier would owe."

Amount in Dispute: $47.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC-060 request was placed in the carrier representative box 47 on March 6, 2007. Debrah Derrickson picked up the DWC060 request on behalf of Burns Anderson Jury & Brenner on March 7, 2007.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2006	99361	$47.00	$47.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202 sets out the reimbursement for guidelines for professional medical services provided between August 1, 2003 and March 1, 2008.
3. Sec. 413.014 sets out the Preauthorization Requirements; Concurrent Review and Certification of Health Care.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 29, 2006
   - 01884 – Unbundling

   Explanation of benefits dated October 2, 2006
   - S – Supplemental payment

Issues

1. Did the requestor obtain voluntary certification?
2. Did the requestor obtain a signed document setting the fee reimbursement for CPT code 99361?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The disputed CPT code 99361 is defined as "Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes." CPT code 99361 is not valued by Medicare." CPT code 99361 is not valued by Medicare.
2. Review of the submitted documentation finds that the requestor obtained voluntary preauthorization for CPT code 99361. The document was signed by Melody Stephen, Work Comp Adjustor on May 25, 2006 representing Gallagher Bassett. The voluntary preauthorization request sets out the reimbursement for CPT code 99361 at $100.00.
3. Review of the Explanation of Benefit (EOBs) dated October 2, 2006 indicates the insurance carrier paid the requester $53.00. The requestor seeks the remaining balance of $47.00.
4. Per Sec. 413.014 "(f) The division may not prohibit an insurance carrier and a health care provider from voluntarily discussing health care treatment and treatment plans and pharmaceutical services, either prospectively or concurrently, and may not prohibit an insurance carrier from certifying or agreeing to pay for health care consistent with those agreements. The insurance carrier is liable for health care treatment and treatment plans and pharmaceutical services that are voluntarily preauthorized and may not dispute the certified or agreed-on preauthorized health care treatment and treatment plans and pharmaceutical services at a later date."
5. Per Sec. 413.014 "(c) The carrier is liable for all reasonable and necessary medical costs relating to the health care: (2)per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section."
6. Per Sec. 413.014 "(r) The requestor and carrier may voluntarily discuss health care that does not require preauthorization or concurrent review under subsections (p) and (q) of this section respectively. (2)The carrier may certify health care requested. The carrier and requestor shall document the agreement. Health care provided as a result of the agreement is not subject to retrospective review of medical necessity."
7. Review of the submitted documentation finds that the requestor is entitled to additional reimbursement in the amount of $47.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $47.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $47.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 10, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.